Problems with Voluntary Vouchers

Medicare vouchers would have some serious problems. Private plans might have difficulty in competing with Medicare. Vouchers might also stimulate adverse and preferred-risk selection. These problems would be more severe in the case of traditional insurance plans with greater cost sharing than in the case of HMOs.

Competitive Problems. Private insurers might have cost disadvantages in competing with Medicare. First, private insurers have selling costs while Medicare does not, and the costs of selling insurance to individual aged and disabled persons could be very high. Administrative costs (other than claims processing) for individual health insurance policies average about one-third of their premiums today. Such costs could be reduced substantially, however, if the federal government played an active role in structuring the choice system. This would probably require limiting the number of traditional insurers offering plans in an area, standardizing benefit packages, conducting the enrollment process, and adjusting Social Security checks for premiums and rebates. Some advocates of vouchers would shy away from such an activist role for government, however.

The costs of private insurers would also be higher for another reason: they must often pay providers at higher rates than Medicare. The problem is most serious for hospital care, where Medicare, with few exceptions, does not permit additional charges to the patients. Data from the Health Care Financing Administration indicate that Medicare determinations of allowable hospital costs averaged 19 percent less than charges in 1978.[2]

The competitive disadvantage of private insurers is particularly acute in enrolling beneficiaries who want a more comprehensive benefit package than Medicare provides. Today such persons may purchase private policies to supplement Medicare, and more than half of them do so. These purchases of supplemental policies are implicitly subsidized by Medicare, however. The reduction in

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2. A few Blue Cross plans may not face this problem of paying hospitals at higher rates than Medicare. They sometimes have discounts comparable to those of Medicare.

cost sharing that results from purchasing such plans induces higher rates of use of medical services, but Medicare pays a large proportion of the costs of the additional use.[3] If a private insurer was to offer a more comprehensive benefit package as a substitute for Medicare plus a supplemental plan, the premium would have to include the entire cost of the additional use of services.

These competitive problems may explain the lack of enthusiasm shown by private insurers for Medicare vouchers. Given the magnitude of the disadvantages, opportunities for profitable new business would be limited. Indeed, the only way to profit might be through selective marketing (discussed further below). Reputable insurers would not find the prospect appealing, especially since less reputable competitors might move in.

These competitive problems would affect HMOs, but to a lesser degree than traditional health insurers. First, many HMOs either have their own hospitals or obtain discounts through bulk purchasing of hospital care, reducing Medicare's advantage. Second, HMOs offer more than just a different benefit structure than Medicare. Their alternative delivery systems emphasize comprehensiveness of benefits and coordination of services that might be attractive to some Medicare enrollees on other than financial grounds.

Adverse and Preferred-Risk Selection. Vouchers could lead to substantial adverse and preferred-risk selection, and thus increase rather than reduce federal outlays. Again this would be less serious for HMOs than for traditional private plans.

Persons choosing to use vouchers to purchase traditional private health insurance policies would likely be lower users than those remaining in Medicare, for two reasons. First, private plans would be more attractive to those interested in less extensive benefits than to those seeking more extensive benefits. Second, insurers would have strong incentives to market selectively in order to obtain the best risks.

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3. For example, the supplemental plan may pay the 20 percent coinsurance for physician services. But if physician visits increase by 20 percent because of the extra insurance, Medicare pays 80 percent of reasonable charges for the additional visits--or, in this case, 40 percent of the full costs of the additional coverage.

Vouchers would be quite unattractive to persons seeking traditional plans with more comprehensive benefits than Medicare because private supplements are already available--implicitly subsidized by Medicare (see footnote 3 above). In most cases, Medicare plus the supplemental plan would have a lower price than a private plan obtainable with a voucher.

Since some persons seeking less extensive coverage might find vouchers attractive, while few seeking more extensive coverage would, the adverse selection would tend to be to the disadvantage of Medicare. In other words, the costs to the federal government of the vouchers for persons opting out of Medicare would exceed what their Medicare benefits would have cost had they remained, so federal spending on the program would increase.

In the case of HMOs, adverse selection would be a very different phenomenon, but the direction, at least initially, would be the same. Since HMO benefits would tend to be similar to those in Medicare, there would be no chance for low users to gravitate toward less comprehensive plans. But persons switching to group-practice HMOs tend to be low users (see Chapter II). Even if the difference eroded over time, federal outlays consistently could be higher than under current policies, especially if large numbers of beneficiaries switched to HMOs each year.

Finally, preferred-risk selection could also be a serious problem. As discussed in the section on individual choice in Chapter II, it would pay insurers to enroll persons likely to be low users. Preventing this by regulation would not be feasible because of the difficulty of proving intent.[4] The net result would be a transfer from Medicare to those insurers who succeeded in such endeavors. The problem could be reduced significantly by a highly structured voucher program. To the extent that the federal government limited the number of plans, did the marketing itself, and standardized benefits, most opportunities for preferred-risk selection would be eliminated.

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4. Insurers could, for example, target marketing campaigns to areas having populations that are relatively young and well-off.

Mandatory Vouchers

Some of these problems might be dealt with by making vouchers mandatory, at least for those newly eligible for Medicare. Medicare would provide only a set amount of funds toward the purchase of a qualified health plan, not reimbursements for covered medical care services.

Mandatory vouchers would eliminate the problems that private health plans would have in competing with Medicare. They would also avoid an increase in federal outlays caused by adverse and preferred-risk selection, since voucher amounts would not be affected by such developments.

On the other hand, mandatory vouchers would have several negative features. They might channel a significant amount of resources into the process of choice among plans. The selling costs discussed above would be included in the premiums paid by all of those eligible for Medicare. The voucher amount would either reflect the selling costs directly--thereby raising federal costs for the same coverage--or enable beneficiaries to buy less coverage for the same federal cost. Moreover, adverse and preferred-risk selection might result in a significant transfer of resources from the high users to the low users. Structuring the voucher system would reduce these problems considerably, but at the sacrifice of some competition. In addition, Medicare would lose its ability to use its purchasing power to drive a hard bargain with providers on behalf of taxpayers.[5]

Perhaps more important than the pros and cons outlined above is the change in the nature of the Medicare entitlement that would be associated with mandatory vouchers. Under current law, persons eligible for Medicare are entitled to reimbursement for a defined set of medical services when needed. As the cost of purchasing these services has soared, federal reimbursements have increased automatically. Under a mandatory voucher, the entitlement would be not to reimbursement for services but to a certain amount of money to be applied toward the premiums of qualified private health plans.

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5. As discussed earlier in the chapter, Medicare pays hospitals considerably less than their charges. To the extent that charge-paying insurers replaced Medicare under a mandatory voucher system, these gains to taxpayers would be lost.

The entitlement might be set equivalent to the current cost of the service entitlement, but it could be set lower. For example, some have proposed basing the voucher on current spending in Medicare and indexing it by the GNP deflator. If the GNP deflator increased by six percentage points per year less than per capita spending in Medicare, as is projected, the voucher amount would soon be substantially less than the cost of the services included in Medicare today. To the extent that beneficiaries enrolled in plans whose premiums grew more slowly than Medicare spending, the problem would be reduced. On the other hand, the voucher amount could be indexed by a more generous factor so as not to affect the level of federal support for health services for Medicare beneficiaries, or a compromise might be found between the need to reduce the budget deficit and the needs of the elderly.

OTHER MEDICARE OPTIONS

A number of other options are available that could increase the role of market forces in Medicare. Reforms in the method of reimbursing HMOs could supply financial incentives to increased enrollment. Cost sharing could be increased several ways--by applying a surcharge to the premiums of supplemental insurance policies, by offering a choice of plans within Medicare, or by altering the Medicare benefit structure.

Reimburse HMOs on a Capitation Basis

Medicare could reimburse HMOs on a capitation basis instead of the present fee-for-service basis. For example, under H.R. 3399, a bill introduced by Congressman Waxman and reported by the Committee on Energy and Commerce, and under S. 1509, introduced by Senator Heinz, Medicare would pay HMOs an amount per enrollee equal to 95 percent of what Medicare spends on similar persons in the area who obtain care through the fee-for-service sector. If the HMO's costs were lower, the excess would have to be applied to the cost of services not included in the Medicare benefit package.

This option is broadly similar to the voucher system. Both would pay a fixed amount and establish a potential financial reward to those enrolling in efficient HMOs. Both initially would tend to increase Medicare outlays as a result of adverse and preferred-risk selection and by rewarding those beneficiaries

already enrolled in efficient HMOs. (If an HMO has costs 20 percent below fee-for-service costs, for example, Medicare now gains most of the savings for current enrollees. Under H.R. 3399, Medicare's gain would be limited to 5 percent of fee-for-service costs.)

The H.R. 3399 approach has one possible advantage over the voucher system in that it would limit opportunities to opt out of Medicare to those enrolling in HMOs. Since consumer choice is more important to the HMO strategy than to the cost-sharing strategy, this limitation to encouraging HMO enrollment might be desirable. A smaller number of Medicare beneficiaries would be involved and the extent of adverse selection would probably be less, so that the increase in federal outlays would be substantially smaller than under some voucher proposals. Of course, restricting the alternatives to enrollment in HMOs would require that they be defined for the purposes of such a program. A tight definition of HMOs would exclude some alternative delivery systems and thus perhaps stifle some innovation.

Encourage More Cost Sharing

Given the shortcomings of vouchers in furthering the cost-sharing strategy, the following options might be considered.

Tax Premiums for Supplemental Policies. Earlier in the paper, the mechanism was described by which the purchase of private insurance to supplement Medicare increases federal outlays and reduces cost sharing. A tax equal to the amount of additional costs to Medicare--about 35 percent of the private plan's premium--could alleviate this problem. The proceeds of such a tax might be dedicated to the Medicare trust funds

Such a tax would have two major effects. First, cost sharing would increase. With the implicit subsidy from Medicare to purchasers of supplemental plans offset by the tax, some participants would decide that supplemental coverage was not worth the price and would instead pay deductibles and coinsurance out-of-pocket at the time that services are used.

Second, it would reduce federal costs for Medicare. Some of the savings would come from surcharge receipts while the remainder would come from lower rates of Medicare claims by those deciding

to discontinue their supplemental policies. In all, the federal deficit would be reduced by $2.5 billion in fiscal year 1983 and by $17.7 billion over the 1983-1987 period.

This option would lead to more equal government aid for all participants by requiring those with private supplemental coverage to bear the additional costs they impose on the Medicare system. Elderly and disabled persons with the lowest incomes would not be affected because their deductibles and coinsurance are paid by Medicaid. But by discouraging the purchase of supplemental coverage, some who would otherwise have purchased it would face difficulties in meeting out-of-pocket costs during a year of unusually high medical expenditures. Supplemental plans that provide only catastrophic coverage might be excluded from such a tax.

Offer a Choice of Plans within Medicare. Medicare could develop a series of options with different benefit structures. Persons choosing an option less comprehensive than the current Medicare benefit structure would get a cash payment reflecting Medicare's claims experience with the option. Those selecting a more comprehensive option would pay an additional premium. These cash payments and additional premiums could vary by age, sex, location, and other relevant actuarial factors.

Such a choice would probably increase the average degree of cost sharing. Those seeking less cost sharing can already purchase supplemental policies at favorable premiums, so the number of persons choosing less cost sharing (either through a new Medicare option or by continuing their supplemental policy) would probably not increase much from current levels. In contrast, those seeking more cost sharing, who have no opportunity to do so today, would be more likely to change plans.

This option would have three advantages over Medicare vouchers as part of a cost-sharing strategy. First, it would economize on resources devoted to selling health plans, since an annual offering by Medicare might be far less costly than marketing campaigns by competing private insurers. Second, preferred-risk selection (but not adverse selection) would be eliminated, since Medicare would offer all the options. Third, it would retain the hospital discount that Medicare has achieved through its purchasing power.

Medicare outlays could still increase, however, if the entitlement to the current array of services was maintained, but those leaving the basic plan were lower than average users. Taxing premiums for supplemental policies at the same time would make such an increase in outlays less likely, since switching from basic Medicare to other plans would be attractive to higher than average users as well as lower than average users. This option would not increase enrollment in HMOs or other alternative delivery systems, but that could be mitigated by combining it with a voucher restricted to HMOs or with capitation reimbursement of HMOs.

Restructure Medicare Benefits. A more direct approach to increasing cost sharing would be a change in the Medicare benefit structure. Under the Medicare Hospital Insurance (Part A) program, patients pay a deductible equal to the estimated average cost of one day's hospitalization--$260 in calendar year 1982 and about $300 by 1983. They also pay coinsurance charges (generally 25 percent), but only after 60 days of hospitalization for a particular spell of illness. Consequently, very few Medicare patients--about 0.2 percent--pay hospital coinsurance in any year.

In addition to the first-day deductible, beneficiaries could be required to pay 10 percent of the amount of the deductible for each of the next 30 days of a hospital stay in each calendar year--about $30 per day in 1983. Medicare would cover all charges in excess of any stay beyond 31 days, or of separate stays totaling more than 31 days in a year, thus improving coverage for participants with unusual hospitalization needs. Enrollees would pay only one $900 deductible, no matter how many times hospitalized in a year.

This option would implicitly set a maximum yearly out-of-pocket individual liability for hospital costs of about $1,200 for 1983. The Medicaid program would continue to pay the coinsurance costs for those elderly and disabled persons enrolled in both programs. Enactment of this proposal would save $1.1 billion in fiscal year 1983 and over $7 billion during the 1983-1987 period.

Coinsurance provisions would limit federal expenditures in two ways. These provisions would make the patients responsible for part of the costs, directly reducing required federal outlays. In addition, hospital patients who pay part of the cost of

their care would probably become increasingly concerned about holding down medical expenditures, limiting both their admissions and lengths of stay. The latter impact would be reduced significantly to the extent that private supplemental plans were revised to cover the new coinsurance charges. Research does not indicate whether increases in Medicare cost sharing would increase or decrease the proportion of beneficiaries who purchase supplemental plans.

Under this option, out-of-pocket costs would rise substantially for the majority of elderly and disabled who are hospitalized. Only a small number of Medicare participants would benefit from the improved catastrophic coverage in any one year, whereas the potential $1,200 in cost-sharing represents about 15 percent of average per capita income for the elderly. In addition, since physicians' fees are currently subject to coinsurance under Part B of Medicare, the burden of an illness requiring hospitalization could rise to well over $1,200. Moreover, persons ineligible for Medicaid who could not afford the cost sharing might forgo some needed medical care.

This conflict between the need to economize on the use of medical services and the burden that cost sharing would place on low-income beneficiaries might be resolved by varying coinsurance rates with income. For example, low-income persons could be assessed 5 percent of the amount of the deductible while all others could pay 15 percent.

The administrative difficulty of varying coinsurance rates by income would depend on how refined were the criteria used to determine who was entitled to the lower rates. The simplest would be based on the level of Social Security benefits. Beneficiaries who were hospitalized and whose monthly benefit was below a certain amount could apply to their Social Security office to obtain the lower coinsurance rate.

Some might consider such a criterion to be inequitable, since among persons with low Social Security benefits some might have high incomes from other sources. A second criterion might be added--for example, that low Social Security benefits and low adjusted gross income be required to get the low coinsurance rate. This would be feasible, though more complicated than the first.

Restricting income-testing to hospital benefits, as in this option, would keep the administrative workload down. Only 22 percent of Medicare beneficiaries have a hospital stay during a calendar year.

Although this option would make patients sensitive to the quantity of medical care used, it would not directly encourage use of lower-cost facilities. A different option could be designed to give patients incentives to use less expensive hospitals. Medicare hospital benefits for days 2 through 31 could be based on average per diem costs in hospitals in an area, for example. Patients would then be liable for the difference between that amount and the hospital's allowable cost. Patients in low-cost hospitals would therefore pay less than those in hospitals with higher than average costs.

A technical problem requiring resolution is that of differentiating between patients requiring many ancillary procedures per day and those requiring few. Unless the Medicare payment and the additional amount that patients were liable for were varied according to diagnosis, hospitals would be given a powerful incentive to admit only patients requiring few services. Basing cost sharing on services ordered rather than on days of care might alleviate this problem.

APPENDIX. INDIVIDUAL CHOICE

Many of those who favor increased use of the market in medical care envision a process of "fair economic competition" in which consumers would choose among health plans.[1] Employers contributing to health plans, and Medicare through a voucher program, would pay the same amount regardless of the plan selected, so that consumers would be rewarded for selecting plans with low premiums. This mechanism is seen as fostering competition among plans, and opening up markets for new plans that are more cost-effective.

While individual choice has the potential to stimulate competition among health plans, it also encounters a number of problems that could seriously impair its effectiveness. These include:

- o Adverse and preferred-risk selection;
- o Administrative costs; and
- o Contract complexity.

This appendix discusses each of these problems.

Whatever the merits of individual choice, one should note that it is not essential in using the market to contain medical care costs. Under the cost sharing strategy discussed in Chapter II, insurance benefits could be altered without individual choice. Employers could shift some of their payments for health insurance to cash or other fringe benefits, and cost sharing in Medicare could be increased. While individual choice is required for the HMO strategy, the problems raised tend to be less severe when the choice involves HMOs.

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1. See, for example, Alain C. Enthoven, Health Plan (Addison-Wesley, 1980).

ADVERSE OR PREFERRED-RISK SELECTION

When consumers choose among health plans, the result is unlikely to approximate that of a random sorting. Consumers will be likely to take into account their expected rate of use of services; while insurers, for their part, are likely to attempt to enroll a disproportionate number of those they expect to be low users of services. The former process is often referred to as adverse selection, while the latter is called preferred-risk selection, both terms reflecting the perspective of insurers. Each process results in a shift of resources from those expecting to be high users to those expecting to be low users, and could diminish the effectiveness of individual choice in spurring competition. A major issue is how much selection is tolerable in order to gain the benefits of individual choice, and whether selection could be kept below this amount.

Adverse Selection

Adverse selection shifts resources among individuals by changing the premiums of experience-rated health plans. Those who choose plans enrolling people who use less medical care than average gain from a low premium reflecting that pattern of use, while those choosing plans that enroll people who use more medical care than average lose by paying a higher premium than otherwise.

Consider a hypothetical example of an employer-sponsored plan that costs $200 per month per family and covers all acute medical care in full (see Appendix Table 1). The employer introduces a low-option plan that pays 80 percent of all acute medical bills and pays a rebate to those choosing this plan equal to the amount by which its premium is less than $200 per month. If a random selection of the firm's employees choose the low option plan, its cost will be $139 per month and the rebate $61 per month.

But those choosing the low-option plan will likely have been lower-than-average users of medical services. If their spending under the high-option plan would have been 20 percent less than the average, the premium for the low-option plan might fall to $114 per month, increasing the rebate to $86 per month. The premium for the high-option plan would increase to about $237, requiring a contribution by employees of $37 per month unless the employer chose to increase its payment by this amount.

APPENDIX TABLE 1. HYPOTHETICAL EXAMPLE OF CHOICE WITH ADVERSE SELECTION

	No Choice	Choice with Random Selection	Choice with Adverse Selection
High Option			
Premium	$200	$200	$237
Rebate	0	0	-37
Low Option			
Premium		139	114
Rebate		61	86

NOTE: The following assumptions underlie this example:

-- Administrative costs are $15 per month.

-- The high-option plan has full coverage; the low-option plan pays 80 percent of bills.

-- Coinsurance in the low-option plan induces a 16 percent reduction in medical spending.

-- Half of the employees choose the low-option plan; their previous rate of use was 20 percent less than average.

Such a shift in resources from those choosing plans with relatively high users to those choosing plans with low users reflects a segmentation of the insured population. In group insurance without individual choice, those expecting high rates of use and those expecting low rates of use are pooled together and pay the same premium. In a sense, the low users subsidize the high users. But under individual choice, the high and low users can assign themselves into different groups, reducing the magnitude of the internal subsidy.

Many consider adverse selection undesirable because of these transfers, but others feel differently. The former group champions the current internal subsidy as socially useful, spreading the burden of high medical costs. The internal subsidy represents a type of insurance against chronic poor health, a spreading of risks that are long-term as well as risks occurring during the policy year. Others object to internal subsidies that do not come directly from government policies, maintaining that only through explicit government action should resources be directly transferred from one individual to another.

In situations where the choice is between a traditional insurance plan and an HMO, adverse selection is a different phenomenon. Here the benefit structures are often similar, so the pattern of selection discussed above does not apply. Selection is more likely to be dominated by the differences between persons willing to change their physician and those who are not, since enrolling in a PPGP-model HMO generally requires such a change. Those willing to change will tend to be relatively low users at the time of change. Once the PPGP enrollments begin to stabilize, the phenomenon may decay--that is, it will probably be more important for new PPGPs than for established ones.[2]

Still another case would be the choice between a high- and low-option traditional insurance program and an HMO. The high-option plan would probably attract those with the highest rates of use, with the HMO attracting the next highest group and the low-option plan those with the lowest expected use. Some advocates of the HMO strategy are particularly fearful that HMOs might attract a relatively high-risk population in those circumstances.

Adverse selection under individual choice may, if it is too pronounced, interfere with competition among health plans. If premium differences among plans were influenced more by adverse selection than by differences in efficiency, consumers would have no way of focusing on the latter in making their choices. This in turn would remove competitive pressure on plans to contain medical costs.

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2. Evidence on this point with respect to Medicare enrollees is discussed below.

Preferred-Risk Selection

The effects of preferred-risk selection are very similar to those of adverse selection. When insurers market to consumers they think to be the lowest users, they segment the market in the same way that adverse selection does, so that the internal subsidy between high and low users is reduced. Under individual choice of plans, opportunities for preferred-risk selection could lead insurers to channel their energies into marketing schemes designed to select good risks rather than into reducing the cost of medical care.

Magnitude of the Problem

Adverse selection and preferred-risk selection would be present under any scheme of individual choice, but their magnitude is difficult to predict. In the limited experience with individual choice, the methods available to control selection were, for the most part, not employed. This section briefly reviews the experience of the Federal Employees Health Benefits Program (FEHBP) and some Medicare demonstrations that offered opportunities to enroll in an HMO with a fixed payment to the HMO by Medicare.[3]

The FEHBP has offered a choice of health plans to federal employees and their families for many years. The federal government makes a proportional rather than a fixed contribution, but since the contribution is capped it is, in effect, fixed for many of the major plans. FEHBP has apparently experienced significant adverse selection, though not enough to put the leading high-option plan out of business or (until last year) to cause much concern about it in the Congress.

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3. The market for individual health insurance policies might also be studied, but it is not a good prototype for the models of individual choice advocated in the Congress. A major way that insurers reduce adverse selection (or engage in preferred-risk selection) is by rejecting applicants in poor health and excluding medical expenses associated with pre-existing conditions. This would not be an acceptable practice for group insurance policies.

Two types of evidence suggest that the Blue Cross-Blue Shield high-option plan has attracted higher than average users. First, utilization rates in the plan are much higher than rates in other government-wide plans, with the differences in most cases too large to explain by differences in cost sharing. The overall hospital utilization rate by enrollees was 9.4 percent in 1979, compared to 7.6 percent in the Blue Cross low-option plan and 7.8 percent and 7.2 percent in the two Aetna plans.[4] For maternity care, 1.6 percent of the Blue Cross high-option enrollees had claims, compared to 1.0 percent in the low-option plan, and 0.6 percent and 0.5 percent in the two Aetna plans.

The second type of evidence concerns patterns of plan-switching out of the Blue Cross high-option plan into other FEHBP plans. Specifically, those switching out of the plan at the end of 1977 had claims for that year 36 percent lower than the average for the plan.[5] Such persons accounted for only 2 percent of Blue Cross high-option enrollees, however. Those switching into the plan from other FEHBP plans in late 1977 had 1978 claims experience close to the average for the plan.

Inference from the FEHBP experience is difficult, however. For one thing, the range of choice is relatively limited because, with the federal government paying 75 percent of the premium up to a ceiling, little incentive exists to enroll in a plan with a premium below the ceiling. Until 1982, when the federal government demanded benefit reductions in plans, no plans had extensive cost sharing. The inclusion of federal retirees in the plans, some with Medicare coverage (which pays first) and some without, also makes inference difficult since the circumstance is unusual.[6]

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4. U.S. Office of Personnel Management, Federal Fringe Benefit Facts 1980, Table D-5.

5. When mental health claims were excluded, the pattern remained, with persons switching out having claims 33 percent below the average. For more detail on this analysis, see the forthcoming Congressional Budget Office paper on catastrophic illness.

6. For additional discussion of differences between FEHBP and the individual choice model advanced by "pro-competition" advocates, see Marsha Gold, "Competition within the Federal Employees Health Benefits Program: Analysis of the Empirical Evidence," November 1981.

Medicare HMO enrollment demonstrations indicate that beneficiaries choosing HMOs tend to be lower users than their counterparts who decline the opportunity. Medicare has contracted with a number of HMOs on a demonstration basis to reimburse them for services provided to Medicare beneficiaries on the basis of Medicare's claims experience with persons of similar age, sex, institutional status, and location.[7] With the exception of one plan, Medicare beneficiaries enrolling in HMOs had used fewer than average services during the four years prior to joining, with the difference averaging about 20 percent.[8] In one of the studied HMOs, enrollees had slightly higher than average use of services prior to enrollment but this site, unlike the others, did not require enrollees to change physicians. Such selection against Medicare and in favor of the HMOs could erode somewhat over time, but many years of continued monitoring of these demonstrations will be necessary in order to determine this.

Minimizing the Problem

Methods are available to reduce the extent of adverse and preferred-risk selection. Adverse selection in choices between high and low options could be reduced by varying rebates or employee costs according to factors such as age, sex, family size, and location. Those expected to be higher users could be given larger rebates for joining plans with lower cost-sharing premiums, for example. If variation in rebates was based on actuarial factors, this could reduce the role of these factors in selection.

While varying rebates by these factors would reduce adverse selection, a significant amount would still remain. A recent analysis by CBO has shown that prior use is a very important determinant of future use of medical services. Among participants in the Blue Cross-Blue Shield high-option plan under FEHBP,

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7. HMOs in the demonstration were reimbursed at slightly less than the Average Adjusted Per Capita Cost (AAPCC), with the percentage of AAPCC varying by site.

8. Paul W. Eggers, "Pre-Enrollment Reimbursement Patterns of Medicare Beneficiaries Enrolled in 'At-Risk' HMOs," Health Care Financing Administration Working Paper OR-31, September 30, 1981.

families whose claims exceeded $5,000 in a calendar year (1982 dollars) had claims in the subsequent year 190 percent above the average claim of $1,203. Part of this difference reflects demographic factors such as age and family size, but when these are removed, families exceeding this threshold still had subsequent-year expenses almost double the average.[9] This pattern of high longitudinal correlation in use has also been found among the elderly.[10]

Further reduction in adverse selection would probably require taking health status into account. Prior claims might be used as a proxy, but this would have problems since those with relatively high use in the recent past would have to be given larger rebates to enroll in plans with low premiums. Besides causing administrative problems, such a policy would provide an incentive to use more medical services.

Reducing preferred-risk selection would be easier, but it would impose a cost. An employer offering a choice of plans could use the same insurer to offer high- and low-option plans, thus eliminating the incentive for insurers to engage in such practices. This might be at the expense of some of the innovation that advocates of market-oriented strategies are counting on, however. Alternatively, the employer could use different insurers but monitor their marketing practices. Reducing preferred-risk selection would be much more difficult under the Medicare voucher, which could not be limited to a single insurer, because monitoring marketing activities would be much more difficult.

ADMINISTRATIVE COSTS

A system of individual choice would inevitably have higher administrative costs than the current system, depending on the organization used. If an employer offered an HMO, its administrative costs would probably be very small, at least if the firm was

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9. This analysis will be described in the forthcoming CBO study on catastrophic illness.

10. Noralou P. Roos and Evelyn Shapiro, "The Manitoba Longitudinal Study on Aging: Preliminary Findings on Health Care Utilization by the Elderly," Medical Care, vol. XIX, no. 6 (June 1981), pp.644-57.

large. FEHBP has low administrative costs even though it offers a relatively large number of plans to employees. On the other hand, selling insurance to individuals could be very expensive. Administrative costs for individual policies are on the order of 35 percent of premiums, as compared to less than 5 percent for very large group policies and 10 percent for all group insurance. The more "open" the competition among insurers, the higher the administrative costs are likely to be. To assess the merits of a greater use of individual choice, the additional costs must be subtracted from the gains in medical care efficiency.

CONTRACT COMPLEXITY

Insurance contracts are complex documents. Their language of individual deductibles, family deductibles, coinsurance, limits, fee screens, exclusions, and the like is difficult for many people to understand. Group insurance lifts some of the burden because a professional--the firm's employee benefits manager or the union's counterpart—does the buying.

Under individual choice, however, the consumer becomes the purchaser of health insurance, and must have a greater understanding of the plans. In fact, such understanding is necessary if individual choice is to be successful in stimulating competition.

Employers offering choice could ease the information problem by making the benefits of different plans as similar as possible. For example, high and low options could be designed so that they differ only by the size of the deductible or the coinsurance rate, or HMOs could be pressured by their group clients to offer the same benefit package--possibly one that resembles that of the high-option plan.

Under a Medicare voucher system, the problem could be more difficult. Standardized options might be opposed on the grounds that they are highly regulatory and would stifle innovation. But to permit a large degree of variation among plans might prevent the elderly from making intelligent choices and subject them to heavy advertising campaigns.